AHIMA
American Health Information
Management Association®

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VIA ELECTRONIC MAIL

Patricia Brooks, RHIA
Senior Technical Advisor
Centers for Medicare and Medicaid Services
Hospital and Ambulatory Policy Group
Mail Stop C4-08-06
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Baltimore, Maryland 21244-1850

Dear Ms. Brooks:

The American Health Information Management Association (AHIMA) respectfully submits the following comments on the ICD-10-PCS code proposals presented at the ICD-10 Coordination and Maintenance (C&M) Committee meeting held on March 18.

Implementation of New Codes on October 1, 2015

AHIMA strongly opposes the implementation of **any** new ICD-10-PCS codes on the ICD-10 transition date of October 1, 2015. We have stated repeatedly that no new codes should be implemented on the ICD-10 "go live" date. By the time new codes would be finalized and released to the public this summer, most healthcare organizations will have completed their implementation preparation activities, including systems changes, education, and internal testing, as well as much of their external testing. Any new codes at that late date would require re-work in terms of systems changes, edits, policies, etc., as well as re-testing, or else organizations would be taking the risk that the addition of the new codes might cause an unexpected glitch. Even though new codes might only be applicable to a small number of patients, they would still need to be incorporated into system applications, and edits and policies would still need to be reviewed to determine if any of the new codes would be applicable for inclusion.

Any last-minute changes after systems modifications and testing have been completed significantly increase the risk of transition glitches and payment disruptions. After the tremendous amount of time and effort the industry has spent on preparing for the ICD-10 transition, and as organizations struggle to complete final preparation steps and testing in the face of limited resources as well as challenges presented by the multiple delays in the transition date, it would be disastrous for a successful ICD-10 transition to introduce code set modifications at this time.

Section X
AHIMA does not support the creation of section X either this year or after the partial code freeze ends.

For the same reasons noted above regarding creation of any new codes this year, we oppose the creation of any new section of codes this year, such as section X. **Adding an entirely new section and set of concepts at the same time that ICD-10 goes live would be very disruptive and jeopardize a smooth transition to ICD-10.**

We do not believe Section X is the proper approach for identifying procedures and services involving a new technology add-on payment application for the following reasons:

- Medical code sets have multiple purposes, reimbursement being just one of them. We do not believe it is appropriate to create a section of codes solely for reimbursement purposes or specifically to meet the requirements of one payer's payment policy. Although the proposed Section X has been compared to the CPT category III codes, Section X is quite different because it seems to be aimed solely at capturing information needed for Medicare hospital IPPS new technology add-on payments. CPT category III codes are not focused on meeting the requirements of any particular reimbursement system. Based on the discussion of Section X at the March C&M meeting, it appears that the primary driver for inclusion of a procedure in Section X is whether or not a request for a new technology add-on payment has been submitted or is anticipated. Without a new technology add-on payment request, there would be no need to create an ICD-10-PCS code to capture services that would not normally be included in ICD-10-PCS or coded by coders.
- Although Section X is titled "New Technology," the definition of new technology for this section is very narrow and seems to be focused exclusively, or at least primarily, on requests for new technology add-on payment under the Medicare IPPS. This is quite different from the CPT category III codes, since "new technology" is defined within CPT and is reimbursement system-neutral. We believe having a section of codes specifically to meet the data requirements of a specific Medicare payment policy involving "new technology" will lead to a great deal of confusion. Since new codes might be created in Section X before the associated new technology add-on payment has been approved, additional confusion regarding the use of these codes may ensue if the add-on payment request is denied.
- AHIMA continues to believe that codes should not be created in ICD-10-PCS for new technologies that are not typically captured or reported in a hospital inpatient procedure coding system, such as identification of specific drugs. These new technologies should be captured via other mechanisms, such as the use of National Drug Codes or Healthcare Procedure Coding System (HCPCS) codes. Use of multiple code sets to capture different types of clinical information is consistent with the approach used by other healthcare data collection and reporting requirements, such as the Electronic Health Record (EHR) Incentive program.

    Although CMS has stated that the use of NDCs or HCPCS codes would present great challenges, there is precedence for utilizing NDCs to identify drugs in the inpatient setting to administer the new technology add-on payment policy. CMS established a methodology

to identify cases for new technology add-on payments by using the NDC for the drug DIFICID® (52015-0080-01) to treat clostridium difficile associated disease (Federal Register / Vol. 77, No. 170 / Friday, August 31, 2012, page 53351). Therefore, we believe this approach is possible, and once it became common practice to identify drugs in this manner, the process would soon become easier and standard practice for both hospitals and CMS. There is also precedence for utilizing HCPCS codes on a very limited basis for Medicare inpatient claims processing, such as payment for blood clotting factor administered to Hemophilia Inpatients (Refer to Medicare Claims Processing Manual Section 20.7.3).

- Inconsistencies in use of the codes could occur as a result of confusion regarding whether the codes in Section X are intended to be stand-alone codes or supplemental codes that should be assigned in conjunction with the code for the primary procedure.

- For procedures that are typically captured in ICD-10-PCS (such as surgical procedures), creating codes in Section X would lead to multiple ways to code the same procedures. Private payers will likely be reluctant to use codes in a section specifically linked to Medicare's new technology add-on payment policy, and so they may require the use of the appropriate code in another section of ICD-10-PCS (such as the Medical/Surgical section) instead, thus resulting in different codes being reported for the same procedure depending on the payer. This would be confusing both for coders as well as researchers and others attempting to analyze coded data.

- The long-term approach to coding procedures classified to Section X would be problematic. As noted above, codes could be created in Section X before the new technology add-on payment application has been approved, resulting in codes being added to this section for procedures for which the add-on payment application was denied. Retaining these codes in a "New Technology" section would be confusing and inaccurately represent these procedures. For procedures for which the new technology add-on payment was approved, that add-on payment would end at some point in the future. It seems inappropriate to retain a code in a "New Technology" section of codes after it is no longer considered new technology, but deleting the Section X code and creating a new code in another section presents its own set of problems, including data trending challenges.

Administration of Blincyto™

Consistent with our past comments, AHIMA is opposed to creating ICD-10-PCS codes to identify the administration of specific drugs. ICD-10-PCS is not intended or designed to serve as a drug terminology. Several drug terminologies, such as the National Drug Codes (NDCs), are available and are designed to identify drugs by name. We strongly recommend that NDCs, an alternative drug terminology, or level II HCPCS codes be used to identify the use of Blincyto™ **if** it is approved for a new technology add-on payment. As noted above, there is precedence for utilizing NDCs to identify drugs in the inpatient setting to administer the new technology add-on payment policy. The value of using multiple code sets to capture and report healthcare data is increasingly being recognized and this approach has been adopted in other programs (e.g., EHR Incentive Program).

We oppose the creation of any new ICD-10-PCS codes on October 1, 2015. If CMS does decide to create an ICD-10-PCS code for the administration of Blincyto™, it should not become effective until October 1, 2016.

Irreversible Electroporation

AHIMA does not support the creation of unique codes for hepatic and/or pancreatic cancer cell destruction using Irreversible Electroporation (IRE). Existing Destruction codes adequately capture this procedure. The presenter acknowledged that the specific method of ablation, such as the use of IRE, is typically not documented in the medical record. Therefore, if a unique code was created, it would be difficult for coders to determine when to assign the code for this technology.

Administration of Idarucizumab

As with our comments regarding the code proposal for the administration of Blincyto™, we recommend other options, such as the use of NDCs or HCPCS codes, be used to identify the administration of idarucizumab if it is approved for a new technology add-on payment. We oppose creation of ICD-10-PCS codes to identify the administration of specific drugs.

We oppose the creation of any new ICD-10-PCS codes on October 1, 2015. If CMS does decide to create an ICD-10-PCS code for the administration of idarucizumab, it should not become effective until October 1, 2016.

Coronary Orbital Atherectomy

We support option 3, the addition of new qualifiers to table 02C, Extirpation of Heart and Great Vessels, in the Medical/Surgical section to differentiate orbital atherectomy from laser, rotational and directional atherectomy procedures. Option 3 allows the identification of number of coronary artery sites. This option also permits all types of atherectomy to be located in the same table.

Per our earlier comments opposing creation of new codes effective this October, new atherectomy codes should not be created until October 1, 2016.

In option 2, creation of a new code in Section X, New Technology, information on the number of coronary artery sites would be lost. It also is not clear whether option 2 is intended to be a stand-alone code, representing both the new technology and the procedure, or whether this code would be used as a supplemental code in addition to a code from table 02C. Option 2 could result in different ways to code the same procedure, depending on the payer. Private payers could require the use of a code from table 02C for coronary orbital atherectomy, whereas the Section X code would be used by Medicare.

Administration of CRESEMBA®

Similar to our comments regarding the code proposals for administration of Blincyto™ and idarucizumab, we recommend other options, such as the use of NDCs or HCPCS codes, be used to identify the administration of CRESEMBA® if it is approved for a new technology add-on payment.

We oppose the creation of any new ICD-10-PCS codes on October 1, 2015. If CMS does decide to create an ICD-10-PCS code for the administration of CRESEMBA®, it should not become effective until October 1, 2016.

Insertion of Tibial Insert

AHIMA supports option 2, creation of a new ICD-10-PCS code in the Measurement and Monitoring section for the use of the VERASENSE™ Knee Balancer System.

Per our earlier comments opposing creation of new codes effective this October, a new code for the use of the VERASENSE™ Knee Balancer System should not be created until October 1, 2016.

Removal of Thrombus and Emboli

This proposal should be brought back to the September C&M meeting. The proposal as presented at the March meeting was confusing and contained inconsistencies. For example, the approaches across the various options are inconsistent. Also, the proposal mentioned "prophylactic" filtering during cardiopulmonary bypass, but the presenter indicated that the procedure for which new codes are being sought is not prophylactic.

Organ Perfusion for Transplants

AHIMA supports option 3, creation of new codes in Section 6, Extracorporeal Therapies, to capture successful organ perfusion for transplant. Documentation of the organ perfusion would need to be included in the recipient's medical record in order for this procedure to be captured.

New codes for organ perfusion should become effective October 1, 2016.

Fenestrated and Branched Endograft

We support option 2, the addition of Device value F, Intraluminal Device, Branched or Fenestrated, to table 04V, Restriction of Lower Arteries, to differentiate between a standard endovascular aneurysm repair procedure and endovascular repair with a branched or fenestrated graft.

New codes for branched or fenestrated grafts should become effective October 1, 2016.

Congenital Heart Anomaly Procedures

We agree that ICD-10-PCS modifications are needed to better capture congenital heart anomaly procedures. Our specific recommendations are as follows:

Modified Blalock-Taussig Shunt

AHIMA supports option 3, the addition of body part values and qualifier values to table 021, Bypass of Heart and Great Vessels.

New codes for the modified Blalock-Taussig shunt procedure should become effective October 1, 2016.

Arterial Switch Operation with Repositioning of the Coronary Artery Buttons

We support option 2, addition of the body part value 0, Coronary Artery, One Site, and body part value 1, Coronary Artery, Two Sites, to table 02S, Reposition of Heart and Great Vessels.

Rastelli Procedure

We support option 2, addition of the body part value H, Pulmonary Valve, to table 02L, Occlusion of Heart and Great Vessels, for coding the oversewing of the pulmonary valve during the Rastelli procedure. As noted in the proposal, the ligation and division of a modified Blalock-Taussig Shunt would not be coded separately.

New codes for oversewing of the pulmonary valve during the Rastelli procedure should become effective October 1, 2016.

Repair of Complete Common Atrioventricular Canal Defect

AHIMA supports option 3, which includes changes in option 2 as well as revision of the definition of the root operation Creation, adding the root operation Creation to the Heart and Great Vessels body system, and adding the qualifier value 2, Common Atrioventricular Valve (applied to the body values G, Mitral Valve, and H, Pulmonary Valve) to table 024, Creation of Heart and Great Vessels.

New codes for repair of complete common atrioventricular canal defect should become effective October 1, 2016.

Truncus Arteriosus Repair

Similar to our recommendations for the proposal above involving repair of complete common atrioventricular canal defect, we support option 3. Option 3 includes the changes described in option 2 as well as revision of the definition of the root operation Creation, adding the root operation Creation to the Heart and Great Vessels body system, and adding the qualifier value J, Truncal Valve (applied to the body part value F, Aortic Valve), to table 024, Creation of Heart and Great Vessels.

New codes for creation of a truncal valve that acts as the aortic valve after truncus arteriosus repair should become effective October 1, 2016.

Enlargement of Existing Atrial Septal Defect and Creation of New Atrial Septal Defect

AHIMA supports option 2, addition of the body part value 5, Atrial Septum, to tables 027, Dilation of Heart and Great Vessels and 028, Division of Heart and Great Vessels, to accurately report the enlargement of an existing atrial septal defect and the creation of a new atrial septal defect.

New codes for enlargement of existing atrial septal defect and creation of new atrial septal defect should become effective October 1, 2016.

Addenda and Key Updates Changes

AHIMA supports the proposed Body Part and Device Key and Addenda revisions.

Thank you for the opportunity to comment on the proposed ICD-10-PCS code modifications. If you have any questions, please feel free to contact me at (312) 233-1115 or sue.bowman@ahima.org.

Sincerely,

Sue Bowman

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